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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **HOME SLEEP TEST APPLICATION**  *Please* ***email*** *to:* [*faxes@nevadasleep.com*](mailto:faxes@nevadasleep.com)  *Or* ***fax*** *to:* ***(702)-990-7665*** | | | | | | | | | | **Date:**   |  | | --- | |  | | | | |
| **All Questions contained in this questionnaire are strictly confidential and will become part of your medical record.** | | | | | | | | | | | | | | | | |
| Last  Name | | | | | | First  Name | | | | M  F | [\_]  [\_] | DOB | | | | |
| Address | | | | | | | | City | | State | | | | Zip | | |
| Email | | | | | | | | Home  Phone | | | | Cell  Phone | | | | |
| Employer | | | | | | | | Job Title | | | | | | | | |
| **MEDICAL INSURANCE INFORMATION (**Insurance companies require the information below for billing purposes) | | | | | | | | | | | | | | | | |
| Do you have insurance? | | Yes  No | [\_]  [\_] | If not, which method will you pay with?  Cash [\_] Check [\_] Credit [\_] | | | | | Name of Primary  Insurance Company | | | | | | | |
| Name of the  Insured/Subscriber | | | | | | | Insured’s  SSN # | | | Relationship  to Patient | | | | | | |
| Policy # | | | | | | | | | | Group ID | | | | | | |
| Insurance claims mailing address | | | | | | | | | | Insurance telephone  number | | | | | | |
| **MEDICAL INFORMATION (**Insurance companies require the information below for billing purposes) | | | | | | | | | | | | | | | | |
| Height (inches) | | | | | Weight (pounds) | | | | | Neck Size (inches) | | | | | | |
| **“STOP” SLEEP SCREENER**  If you check YES to **two or more** of these questions, you are **at risk for unhealthy sleep**. | **S (Snore)** | | | | Do you snore? | | | | | | | | | | Yes  No | [\_]  [\_] |
| **T (Tired)** | | | | Do you feel fatigued during the day? | | | | | | | | | | Yes  No | [\_]  [\_] |
| **O (Obstruction)** | | | | Have you been told you stop breathing at night – **OR –** Do you gasp for air or choke while sleeping? | | | | | | | | | | Yes  No | [\_]  [\_] |
| **P (Pressure)** | | | | Do you have high blood pressure – **OR** – Are you on medication for high blood pressure? | | | | | | | | | | Yes  No | [\_]  [\_] |
| **“BANG” SLEEP SCREENER**  Each YES you check here increases your risk of **moderate to severe unhealthy sleep**. | **B (BMI)** | | | | Is your body mass index greater than 28? *(You can calculate this online)* | | | | | | | | | | Yes  No | [\_]  [\_] |
| **A (Age)** | | | | Are you 50 years old or older? | | | | | | | | | | Yes  No | [\_]  [\_] |
| **N (Neck** | | | | Are you a: male with a neck circumference greater than 17” – **OR** – a female with a neck circumference greater than 16”? | | | | | | | | | | Yes  No | [\_]  [\_] |
| **G (Gender)** | | | | Are you a male? | | | | | | | | | | Yes  No | [\_]  [\_] |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **EPWORTH SLEEPINESS SCALE**  0 = Never  1 = Slight  2 = Moderate  3 = High | **How likely are you to doze or fall asleep in the following situations? This refers to your usual way of life. Even if you have not done some of these things, try to imagine how they would affect you.** | | | | | | | | | | |
| **Situation** | | | | | | | | **Chances of Dozing** | | |
| Sitting and Reading | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| Watching TV | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| Sitting in a public place (theater/meeting) | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| As a passenger in a car for an hour | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| Lying down for a rest in the afternoon (when circumstances permit) | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| Sitting and talking to someone | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| Sitting quietly after lunch without alcohol | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| In a car. Stopped for a few minutes in traffic. | | | | | | | | 0 [\_] 1 [\_] 2 [\_] 3 [\_] | | |
| **Score: 0—7: Normal range 8—11: Borderline 12—24: Excessive daytime sleepiness** | | | | | | | | | **Total Epworth Score** (Sum): | | |
| **WHICH OF THE FOLLOWING SYMPTOMS RELATE TO YOU?** | | | | | | | | | | | |
| Snoring [\_] | | Witnessed Apnea Episodes [\_] | | | | | Excessive Daytime Fatigue [\_] | | | | |
| Cognitive Dysfunction [\_] | | Headaches [\_] | | | | | Trouble getting out of the bed in the morning [\_] | | | | |
| **DO YOU OR HAVE YOU EVER HAD ANY OF THESE CONDITIONS?** | | | | | | | | | | | |
| High Blood Pressure [\_] | | Loss of Productivity [\_] | | | | Drowsy Driving [\_] | | | | | COPD [\_] |
| Heart Problems [\_] | | Cancer [\_] | | | | Stroke [\_] | | | | | Kidney Disease [\_] |
| Obesity [\_] | | Depression [\_] | | | | Diabetes [\_] | | | | | Heart Failure [\_] |
| Alzheimer’s [\_] | | Anxiety [\_] | | | | GERD [\_] | | | | | Lung Problems [\_] |
| **Additional medical history, including pertinent medications such as those to treat the above conditions and narcotic pain medications:** | | | | | | | | | | | |
| Do you use supplemental home  oxygen during sleep/at rest? | | Yes  No | [\_]  [\_] | If yes, what is your  current liter flow? | L/min | | | Typical sleep duration:  hours | | | |
| Do you use a CPAP/BIPAP machine? | | Yes  No | [\_]  [\_] | If yes, what is your  current pressure? | cm H2O | | | Comments: | | | |
| **Additional Comments:** | | | | | | | | | | | |
| **I authorize my sleep study results and all relevant paperwork to be sent to my email address, or to be picked up in person by me** [\_] | | | | | | | | | | | |
| **Signature (printed, typed, or hand-written):** | | | | | | | | | | **Date:** | |
|  | |